Quality Care Consulting

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Dear House Insurance Committee Members:

In reference to Bill 4936, I would like to provide the following information as a Michigander, a case management business owner and, last, as a provider of rehabilitation services. In the information that follows you will find a comparison among auto insurance, private health insurance and governmental insurance. My hope is that this comparison will help to explain the ways in which private health insurance and governmental insurance will not cover many medical expenses when a person finds themselves moderately to catastrophically injured in a car accident.

I would like to start by comparing auto insurance to private health insurance. Prior to that, however, I would like to make known that as a Michigander, I want to pay $145.00 for catastrophic coverage on my vehicle. I want to know that if I am seriously injured that there will be payment for my medical bills. I currently pay $1243.00/month for private health insurance. If I could find a health insurance that would cover catastrophic illness for $145.00 per year, I would gladly trade-in my current plan. Speaking from strictly the worst medical case scenario, my health insurance covers me if I am diagnosed with a catastrophic **illness** while my auto insurance covers me if I am catastrophically **injured**. Although medically similar, the cost difference between the two could not be further apart. In 2003, I was in an auto accident that resulted in moderate injuries to include: right and left shoulder surgery, as well as, 3 herniated discs in my spine. I had American Community as my health insurance carrier. This private health insurance carrier has a policy exclusion stating that they do not pay for auto-related injuries (See Attached American Community Provider Orientation Manual). In addition, many of the exclusions, with regards to rehabilitation therapies and medication, meant that I had to pay out-of-pocket for certain services. For instance, both shoulder surgeries happened in the same year and as such, I exhausted my physical therapy benefits for the year. In addition, the following medical expenses were not covered: durable medical equipment, medication co-pays, office visit co-pays, deductibles and prolotherapy injections. As such, I accumulated $38,000.00 of personal, out-of-pocket, expenses. What this means is that if a person is moderately injured and accumulates bills in excess of $250,000 they would not be able to rely on their private health insurance to pay for all reasonable and necessary costs related to recovery. Amounts would be subject to health insurance exclusions and provisions. As such, those expenses would need to be paid out of pocket at a non-discounted group rate designated by the provider. This would impact every Michigander on multiple levels to include an increase in medical costs and private health insurance rates.

As a Michigander, if I make a mistake and cause an accident, I do not want to experience financial catastrophe when I am sued by the driver I may have hit. I do not want the burden of having to pay for the other drivers medical bills if in fact they choose a policy that does not provide them adequate

coverage for their injuries. I have worked hard and have carefully made a financial plan for myself and my family. I am collectible if sued; to mean that I could have my life earnings taken away only to then join the many in Michigan who are bankrupt and starting over. I can buy more coverage for under-insured motorists but then I am not saving any money on car insurance and instead will end-up paying more in umbrella coverage. I will be paying more for a substandard auto insurance plan compared to what I have now. I pay my auto insurance to be INSURED against catastrophe. If my car is totaled, I can buy a clunker. If I break a bone, I might be able to pay for rehabilitation. If another driver is seriously injured, and I am at fault, OR if I am seriously injured and exceed the 5 million dollar cap, I cannot make-up the financial difference. In other words, I want to pay for a product that covers me in the worst of times. That is what insurance is all about. Anything less is just air. Catastrophic injury coverage should be a part of the product that auto insurance companies are responsible for paying. That is their chosen industry and as such, they are accountable for payment of such injuries. What if BC/BS decided that they were no longer going to pay for catastrophic illness? Would that be a fair product to sell given that they are a health insurance carrier? The same should apply to auto insurance carriers.

I own Quality Care Consulting, a mental health case management company specializing in the rehabilitation of traumatically brain injured individuals. As a business owner, I have been a Chamber of Commerce member for 20 years. A part of the Chamber of Commerce mission is to provide advocacy in representing the small business person and to promote jobs in Michigan. I changed health carriers many years ago when I learned that I could receive a group rate on my employee Blue Cross because I am a member of the Chamber of Commerce. In the past year, I have had 2 increases in my Blue Cross Blue Shield premiums. The impact of such increases is almost immediate in terms of raises for my current staff and my ability to create more jobs as an employer. Although a small business owner, I believe the trends I experience regarding health care costs are the same as a medium to large business owner because I am a part of a larger group via the Chamber of Commerce. If BC/BS, or any other private health insurance, is held responsible for excessively expensive auto claims this will likely increase premium costs to an even higher rate. This would mean that I may have to stop raises, eliminate the health insurance/employee benefit and leave it up to them to figure-out how to obtain their own individual health insurance. This would mean that they would be making less money overall and that I would not be able to hire new employees. If this is the trend that I would experience as a small business owner, I believe the same would be true for medium to larger businesses. This would affect the economy in Michigan as a whole. Auto no-fault reform needs to be in the best interest of every business owner, employee and resident within this state. Can Michigan afford for employers to shoulder the burden of increased health care premiums? Can employees afford to work at reduced salary or hourly rate? Can Michigan afford more job loss? This is some of the inadvertent impact that Bill 4936 will have.

Last, I want to testify as a case manager/medical professional. I am a council member of the Michigan Independent Case Management Council. The auto no-fault system, AS IS, works. Why fix what is not broken? People receive their care, insurers are making a profit and the public is not burdened with the bill. Words like mandated and unlimited have been used as a means of making people feel controlled by the current auto no-fault system. Yes, you are mandated to pay for the best coverage for a nominal amount. In other words, you are "forced" into a really good thing. When an auto insurance claim comes to my office, it is subject to many limit setting measures to include: independent medical evaluation (the insurance company chooses a physician to render their own opinion regarding injuries), suspension of benefits from an unfavorable independent medical examination, peer review as it pertains to medical documentation, the litigation process and numerous eyes on the claim via the providers, case manager, adjuster, medical guardian, probate court judge, defense attorney and plaintiff

attorney. The claims most affected by this bill are catastrophic claims which are claims that have objective findings on MRI's, CT scans, x-rays or neuropsychological testing. It is hard to fake a spinal cord injury and I have yet to meet a head injured individual who wouldn't trade all the money in the world to have their old life back. In that same vein, I have yet to meet a family member who didn't wish that their loved one could walk, talk, communicate, think, behave and/or feel like they did before the accident. As for providers, a majority do this work because their hearts are in the right place. Trauma is hard to witness on a daily basis and many come to this specialty because they want to help or have some personal reference to do this type of work. The work is emotional however it is always a privilege to witness the human spirit overcome adversity. In closing, I want to give you an example of two cases that are the same from a medical standpoint. The difference is only found in the funding sources and the benefits available through those funding sources:
"Fred" was in a car accident where he was seriously injured. He was taken by ambulance to a nearby trauma center and treated for internal bleeding. He was put on a ventilator to make sure his brain received enough oxygen. After emergency surgery, he was placed in the ICU and eventually moved to the general hospital where he was evaluated for speech therapy to improve his ability to swallow and physical therapy to prevent deconditioning. **Disoriented and confused, he was inconsistent with following commands**. As an auto case, even though he was inconsistent with following commands he received speech and physical therapy treatments until his swallowing and strength improved. He continued with rehabilitation with a very good prognosis. All services were paid for through auto funding as all services were found to be reasonable and necessary for the care and rehabilitation of "Fred".

On the other hand, "Mike" was **NOT** involved in a car accident and therefore used his governmental insurance. Like "Fred," he was taken by ambulance, with internal bleeding, to a nearby trauma center and treated. After emergency surgery, he was placed in the ICU where his recovery continued. Exactly like "Fred," He was placed in the general hospital and was evaluated for speech and physical therapy. "Mike" was inconsistent with following commands and, this is where the stories differ. "Mike" was labeled unrehabilitative. Under his governmental insurance, he had to meet a threshold of criteria that included being able to follow commands. Unable to meet this criteria, no physical or speech therapy was provided. He became deconditioned and received no treatment to improve his swallowing. He continued to deteriorate. His prognosis was very poor and as a result he never regained his ability to eat independently or walk because he didn't receive the necessary services. As you can see, when comparing "Fred " and "Mike" you have two medically similar cases with two different funding sources. I n "Fred's" story his condition was treatable, and fortunately for "Fred" ANF paid for his services. While in "Mike's" story, although the condition was treatable, he was not afforded the same care because of the threshold of criteria within his governmental insurance.

I hope that all of the information above helps to clarify the differences between private insurance, government insurance and auto insurance. Private insurance has exclusions that will prohibit certain necessary rehabilitation services. Government insurance has certain thresholds that most brain injured patients would not be able to meet: primarily following commands. There is a difference between private, governmental and auto insurance. There are many loopholes within the private and governmental insurances that would need to be closely examined to truly understand the full impact of this Bill. This Bill will impact the cost of private health insurance and raise the premiums. These costs will have to absorbed somewhere and will reduce hourly rates, number of employees and/or will result in costs for medical care that will need to be passed on to the employee.

Thank you this opportunity to share my thoughts with you. Please know that if you have any questions about the different funding medical sources, I will make myself available to you.

Respectfully,

Karen L Amick, MA, LP. CMC

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CEO of Quality Care Consulting
Clinical Director
Limited Licensed Psychologist
Care Manager Certified

American Community
Provider Orientation Manual

The Provider Orientation Manual is a reference tool designed to assist our participating providers, and their office staff, with American Community's administrative procedures.

The Provider Orientation Manual is maintained on-line and updated periodically. Please refer to the Provider Orientation Manual frequently for updates, changes and additions.

If you have questions, please contact the Network Development Department at:

Phone: 800-991-2642 ext 6370
Fax: 734-853-2290
Email: Providers@american-community.com

Thank you for participating in the American Community Provider Network.

AMERICAN COMMUNITY
PROVIDER NETWORK

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Section 1

Explanation of Benefit Remark Code Definitions

Below is a comprehensive listing of American Community's explanation of benefit remark codes:

EOB Remark Codes - Not Covered or Excluded:

1A Your policy provides no benefits for prescription drugs except for those that are obtained through our mail order program.

1B Your policy provides no coverage for prescription drugs.

1C Using your discount drug card at participating pharmacies helps to reduce your out-of-pocket expenses.

1P When you use your discount card at a participating pharmacy, for covered drugs, your claim is automatically submitted to us within two weeks of the fill date. It is not necessary to mail your prescription receipts to us.

1R Policy is currently not active due to outstanding delivery requirements. Please have the policy holder contact our policy
administration department at 1-800-991-2642, extension 4484, for additional information.

2A Your policy provides no benefits for emergency room treatment of a non-emergency illness.

2B Your policy excludes treatment of obesity.

2L We are unable to process your claim without the provider's credentials. Your provider must submit their credentials along with a copy of their license.

2W Your policy does not cover surgery for weight loss.

02 Your policy does not cover expenses incurred for the treatment of conditions excluded from coverage by your policy rider.

3B Your policy does not cover allergy testing and allergy treatment including allergy injections.

3G Your policy excludes expenses as a consequence of a family member being intoxicated or under the influence of any non-prescribed controlled substance or narcotic, unless administered on the advice of a physician.

3F Your policy does not cover expenses incurred for the treatment or removal of nevi, keratoses, skin tags, or warts.

Section 1

84 Your policy does not cover expenses incurred for voluntary sterilization and reversal of sterilization.

85 Your policy does not cover expenses incurred for voluntary abortion.

86 Your policy does not cover expenses incurred for contraceptives or contraceptive methods.

87 Your policy does not cover expenses incurred for fertility drugs, artificial insemination or in vitro fertilization.

88 Your policy does not cover expenses incurred for drugs prescribed for mental or nervous conditions.

89 Your policy does not cover medical expenses unless the patient is confined in a hospital as an inpatient.

9B Your policy does not cover expenses related to the diagnosis and/or treatment of infertility or fertilization procedures.

90 Your policy does not cover expenses incurred for injuries resulting from ownership, operation, maintenance or use of a motor vehicle.

91 Your policy does not cover travel expenses, except for emergency local ambulance.

92 Your policy does not cover care and services performed by volunteers, relatives and residents of the insured's household.

93 Your policy does not cover care, treatment, and services provided by your employer.

94 Your policy does not cover expenses incurred for the treatment of eating disorders.

95 Your policy does not cover expenses incurred for weight loss programs, exercise programs or equipment.

96 Your policy does not cover expenses incurred for smoking cessation.

A1 We have notified the hospital that they must send an itemization of charges for each day of confinement to 39201 Seven Mile Rd., Livonia, MI 48152. We are unable process this claim based on the summary of total charges submitted.

A2 Your provider billed us for an unidentified service. We have notified them that they must submit a description of services to 39201 Seven Mile Rd., Livonia, MI 48152.

A3 Benefits have been reduced because this service was not pre-certified within the time requirements specified in your policy. This amount is the patient's responsibility.

A5 We previously requested information from a provider that was necessary to process this claim. Until we receive this information, we are unable to conclude processing.

A6 This procedure is usually not performed more than once in a single day. We have notified your provider that we will reconsider this service if they submit an explanation for performing it more than once.